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Smoking Cessation Counseling for Asian Immigrants With Serious Mental Illness: Using RE-AIM to Understand Challenges and Lessons Learned in Primary Care–Behavioral Health Integration

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Abstract

Engagement in modifiable risk behaviors, such as tobacco use, substantially contributes to early mortality rates in individuals with serious mental illness (SMI). There is an alarmingly high prevalence of tobacco use among subgroups of Asian Americans, such as immigrants and individuals with SMI, yet there are no empirically supported effective smoking cessation interventions that have been tailored to meet the unique cultural, cognitive, and psychological needs of Asian immigrants with SMI. In this article, we share the experiences of clinicians in the delivery of smoking cessation counseling to Asian American immigrants with SMI, in the context of an Asian-focused integrated primary care and behavioral health setting. Through a qualitative analysis of clinician perspectives organized with the RE-AIM framework, we outline challenges, lessons learned, and promising directions for delivering smoking cessation counseling to Asian American immigrant clients with SMI.

Keywords

Asian; minority health; cessation; tobacco prevention and control; cultural competence; community intervention

INTRODUCTION

Tobacco use is extremely prevalent among individuals with serious mental illness (SMI; defined as any past year *DSM-IV* [*Diagnostic and Statistical Manual of Mental Disorders*, fourth edition] mental, behavioral, or emotional disorder resulting in functional impairment that substantially interfered with or limited one or more major life activities; Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act, 1992, Public Law 102–321).

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Epidemiological data suggest that individuals with mental illnesses and/or substance abuse are up to 3 times more likely than individuals without SMI to smoke (McClave, McKnight-Eily, Davis, & Dube, 2010) and consume approximately 44% to 46% of cigarettes sold in the United States (Grant, Hasin, Chou, Stinson, & Dawson, 2004; Lasser et al., 2000). In part as a consequence of smoking and other modifiable risk behaviors, individuals with SMI die on average 25 years sooner than individuals without SMI (Agency for Healthcare Research and Quality, 2009). To address these stark disparities, there has been a push in the past 5 years toward better integration of primary care and behavioral healthcare (Centers for Medicare & Medicaid Services, 2010) and services that encourage self-management of chronic conditions, prevention, and health promotion for those with SMI. Given that smoking is a modifiable risk behavior linked to preventable mortality and morbidity (U.S. Department of Health and Human Services, 2004) and which interferes with the metabolism of antipsychotic medications (Ziedonis & George, 1997), the provision of effective smoking cessation interventions for individuals with SMI has become an important research and public health priority (Ranney, Melvin, Lux, McClain, & Lohr, 2006). Furthermore, more work is needed to better understand how mental illness intersects with ethnic minority status to influence smoking behaviors and cessation interventions.

BACKGROUND

Asian Immigrants With Serious Mental Illness

Among Asian Americans—of whom 15.5% reported a mental disorder in the past year (Substance Abuse and Mental Health Services Administration, 2010)—immigrant males and Southeast Asians are at greater risk for tobacco use compared with the general population (Chae, Gavin, & Takeuchi, 2006; Liao et al., 2010; Ponce et al., 2009). Smoking is heavily influenced by social and cultural norms (Unger et al., 2003) and individuals from different ethnic/cultural groups vary with respect to the barriers to smoking cessation (Fiore et al., 2008).

Culture shapes how health and illness are experienced by both the individual and his or her family and community because members of different cultures vary in their belief systems, values, and relational and personality styles (Saw & Okazaki, 2012). For example, previous research has demonstrated that Asians are more oriented toward preserving face (i.e., moral and social standing) compared with Whites and that face influences stigma about illness and help-seeking behaviors (Yang et al., 2007). This may help to explain prior findings demonstrating that Asian Americans underutilize mental health services (Abe-Kim et al., 2007) and, specifically among smokers, are less likely than the general California population to have sought out a health provider in the past year (Tong, Tang, Chen, & McPhee, 2011).

There is limited research on how SMI may influence smoking for Asian immigrants; however, using data from the California Vietnamese Tobacco Use Survey, Tong et al. (2010) found mental illness—specifically depressive symptoms—to be a risk factor for smoking. Other factors related to tobacco use pointed to indications of historical trauma, including time in reeducation camps and/or serving in the military or police force in Vietnam. Furthermore, Tsoh and colleagues have documented associations between

depressive symptoms and smoking among Chinese Americans in two separate community samples (Luk & Tsoh, 2010; Tsoh, Lam, Delucchi, & Hall, 2003).

The Need for Adapting Smoking Cessation Interventions for Asians With Serious Mental Illness

Although there is a general consensus that smoking cessation programs, especially those that integrate psychological interventions (e.g., cognitive–behavioral therapy) with pharmacotherapy (e.g., nicotine replacement therapy) are effective, there is as yet insufficient evidence in the research literature supporting the effectiveness of these interventions for individuals with SMI (Ranney et al., 2006). The few clinical trials that have evaluated the effectiveness of smoking cessation programs for individuals with SMI have used very small samples ranging from nine to 70 participants. These studies tend to demonstrate modest quit rates and high relapse rates (Hall & Prochaska, 2009). Furthermore, despite growing evidence that many ethnic minority smokers are interested in quitting and responsive to interventions (Cox, Okuyemi, Choi, & Ahluwalia, 2011) and culturally tailored interventions are effective for ethnic minorities with mental illness (Smith, Domenech Rodriguez, & Bernal, 2011), there have been no previous studies examining the effectiveness of smoking cessation programs designed or adapted for ethnic minorities with mental illness.

Conducting effectiveness research and implementing empirically supported treatments are daunting tasks in community settings. Community clinics, especially those serving high need, underserved populations, face internal and external pressures that make implementation challenging. In some settings, the objectives and goals of a treatment may not match the needs of the clinic clientele or may not be suited for implementation by the clinic staff (Zapka, Goins, Pbert, & Ockene, 2004). Translation of empirically supported treatments into practice inevitably involves changes made to protocols—changes which are often not well documented or understood (Cohen et al., 2008). Furthermore, for populations with limited English proficiency, interventions cannot simply be translated from English to the target population’s native language, but instead must incorporate cultural concepts and account for complexities in language (e.g., variations in dialect within the same language; Brugge et al., 2002; Tu et al., 2008). Linguistic and cultural issues, therefore, add additional challenges to translation and evaluation of smoking cessation interventions in ethnic community settings.

The purpose of this article is to discuss challenges faced and lessons learned in the delivery of smoking cessation counseling to individuals with SMI. We use the case example of an Asian immigrant–focused, community-based clinic within a behavioral health–primary care integration context. Rather than a formal evaluation or a fully employed use of the RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) framework (Kessler et al., 2013), we instead use RE-AIM (Glasgow, Vogt, & Boles, 1999) as a guide to report a community-generated reflection that has implications for policy and practices of tobacco control/smoking cessation among Asian immigrants with SMI.

METHOD

Theoretical Framework

We draw from the RE-AIM model (Glasgow et al., 1999) to guide our analysis and discussion. The RE-AIM model allows for the evaluation of the impact of health promotion interventions on different levels (i.e., individual, organization, community) across the five dimensions of reach, effectiveness, adoption, implementation, and maintenance. The RE-AIM framework offers an alternative to implementation science under highly controlled conditions with homogenous, uncomplicated participants; rather, the model is suited for use under real-world conditions.

Clinic Background

Asian Community Mental Health Services (ACMHS) is a nonprofit mental health clinic in Oakland, California, established in 1974 to provide comprehensive outpatient mental health and substance abuse treatment services. ACMHS provides mental health services to more than 1,000 adult clients annually, including more than 400 with SMI. These clients are mostly low-income immigrants with limited English proficiency and represent more than 10 distinct Asian languages (see Table 1 for a snapshot of ACMHS' client population in 2005). In 2010, ACMHS received a grant from the Substance Abuse and Mental Health Services Administration to integrate primary care and wellness into their existing behavioral health services for clients with SMI. As part of their grant efforts, along with a small treatment incentive grant awarded by the Alameda County Behavioral Health Care Services (California), ACMHS began offering smoking cessation to these clients. Below, we highlight some of the lessons learned and opportunities for improving smoking cessation counseling for Asian immigrants with SMI.

Smoking Cessation Counseling Program

The smoking cessation program used by the clinic are drawn from several sources, including curricula developed by Alameda County Provider Network for Tobacco Dependence Treatment and Cessation, American Lung Association, and University of Medicine and Dentistry of New Jersey (Williams et al., 2009). All practices are empirically supported, consistent with the 2008 U.S. Department of Health and Human Services' Treating Tobacco Use and Dependence guidelines (Fiore et al., 2008), and emphasize the Surgeon General's "Five Keys for Quitting Smoking" (i.e., Get ready; Get support; Learn new skills and behaviors; Get medication and use it correctly; and Be prepared for relapse or difficult situations; http://www.cdc.gov/tobacco/quit_smoking/how_to_quit/you_can_quit/five_keys/). The interventions combine nicotine replacement therapy (e.g., nicotine patches) with motivational interviewing (Miller & Rollnick, 2002) and cognitive–behavioral counseling. In this article, we focus on a group program offered in English, Korean, and Cantonese Chinese over a 12-week period and one-on-one counseling provided to Cambodian clientele. The rationale for why and details of how these practices were changed from their original design are discussed under the Implementation section and summarized in Table 2.

Data Collection and Analysis Strategy

The first author conducted semistructured interviews with three staff members (two of whom are the third and fourth authors) who provide direct service or supervision in smoking cessation counseling. Interviews were conducted over the phone and lasted between 45 and 75 minutes. Each staff member was asked to describe their role in smoking cessation programming at the clinic, what practices they used, how these practices were similar or different from training received on smoking cessation, unique challenges in providing smoking cessation counseling, their efforts in meeting these challenges, and recommendations for improving smoking cessation counseling for other Asian immigrant clients with SMI. Using constant comparison analysis (Glaser & Strauss, 1967), the interviews were then thematically analyzed and summarized by the first author, who then requested and received feedback from the original interviewees as to the accuracy of the data analysis and synthesis. Based on their collective expertise, all authors supplemented the interview data with other recommendations for improving smoking cessation counseling for the target population. The analyses were then organized based on the RE-AIM framework.

Sociodemographic information on the smoking cessation program participants and process and outcome data were not available, as these data were not collected.

RE-AIM FRAMEWORK

Reach

This dimension refers to the characteristics and percentage of individuals (among those eligible to participate) who participated in the program. At the time the smoking cessation program was offered, approximately 100 clients endorsed tobacco use. Of those 100 who endorsed tobacco use, 20 attended at least one session of a smoking cessation program (either individual or group counseling) being offered by the clinic. Therefore, the initial implementation of the smoking cessation program reached 20% of those eligible to participate. According to the clinicians interviewed, possible characteristics distinguishing participants from nonparticipants were higher psychosocial functioning, higher focus on physical well-being, greater willingness for social interaction, preexisting therapeutic relationship with clinician offering the intervention, and higher motivation to quit smoking.

Effectiveness

Effectiveness captures primary and secondary outcomes that result from the cessation program. Formal process and outcome data were not collected; therefore, assessments of primary outcomes (i.e., reduction or complete cessation of tobacco use) and other outcomes (e.g., health-related quality of life) are not available. Measures of effectiveness will be collected and analyzed in future studies of the cessation program.

Adoption (Staff Level)

The dimension of adoption at the staff level refers to the characteristics and percentage of staff members who participated in the intervention. Because of policies implemented in July 2011 by Alameda County Behavioral Health Care Services, who provide funding to ACMHS, all providers are required to develop the capacity to integrate smoking cessation

interventions into their programs and clinical staff are strongly encouraged to receive at minimum 6 hours of training in evidence-based treatments for smoking cessation. At the time of this writing, all of ACMHS' clinical staff had received at minimum 6 hours of training.

Implementation

Implementation captures adherence to the program as originally designed, adaptations made, and costs of the program in terms of time and money. Because the clinicians providing smoking cessation counseling felt that the protocols on which they had been trained did not fully address their consumers' needs, they made modifications to attempt to better meet the cultural, linguistic, and psychological needs of their clients. We discuss some of these modifications in depth in this section and summarize the changes made in Table 2.

Framing cessation as a component of wellness—Clinicians reported facing tremendous resistance when recruiting clients to smoking cessation programs because many are still reluctant to quit smoking. Furthermore, smoking is often one among many other health issues clients face, so although they may lack motivation to quit smoking, they may be interested in learning about diet and exercise. Therefore, clinicians counseled clients on health and wellness in addition to smoking cessation.

Experiential learning—Clinicians reported that many evidence-based smoking cessation curricula rely heavily on educating clients through lectures and handouts, but their clients found this learning method to be boring. They stated that their clients tend to respond best when learning was experiential and teaching materials were tactile. For example, one clinician often showed clay models of a healthy lung and a lung of a chronic smoker to help her clients better understand the ill effects of smoking. Rather than simply discussing the costs of a pack of cigarettes, clinicians took clients on field trips to nearby convenience stores where they saw the price of cigarettes for themselves.

Addressing culture, spirituality, and gender issues—Clinicians reported that content in existing cessation program materials, such as discussions of diet and exercise, are often not culturally relevant. Although there is little to no discussion of spirituality in these existing materials, spirituality is important to many clients. Therefore, clinicians incorporated meditation and prayer into discussions of alternative behavioral strategies in lieu of smoking and as coping strategies for smoking cravings. Given that motives for smoking often vary by gender, the unique needs of male versus female smokers must be considered. Smoking is considered to be a favored pastime for men in many of the Asian cultures from which the clients originate; therefore, addressing smoking cessation requires attention to the clients' cultural orientation and gender norms. For female smokers, there is considerable variability regarding their attitudes about smoking. Some view smoking as liberating and a right they have earned since moving to the United States. Cambodian female clients tend to chew tobacco more frequently than they smoke, and in some Cambodian communities tobacco chewing is considered a rite of passage into womanhood. Other female clients view smoking as shameful and therefore try to hide or minimize the extent of their

smoking from others. Clinicians were mindful of the complexities of gender and cultural norms about smoking and took time to discuss these issues in counseling.

Emphasizing important relationships as motivators of change—Given the importance of relationship harmony to many clients, clinicians providing smoking cessation counseling often used their therapeutic relationship with clients as well as clients' family relationships to motivate interest in smoking cessation counseling and behavioral change. For example, when clinicians had existing positive therapeutic relationships with clients, they were able to leverage these relationships to recruit their clients to participate in smoking cessation programs. As one interviewee described, clinicians sometimes used the concept of face to motivate their clients to join a smoking cessation group, saying that it would preserve face for the clinician if their client would join.

One ACMHS clinician certified in addiction treatment provided a poignant example of leveraging important family relationships to motivate change. She described one client to whom she provided individual therapy once per week. This client, a Cambodian man, had smoked two packs of cigarettes every day for several decades. At the beginning of counseling, the client was estranged from his adult daughter, who had recently had a child. His daughter was interested in reconnecting with him, but only under the condition that he stopped smoking so that he would not expose his grandchild to secondhand smoke. The client took up the challenge of quitting smoking, choosing to do so without pharmacological assistance. During the course of therapy, his therapist suggested that in place of his cigarette box, he write the names of his daughter and grandchild on a bright piece of paper to remind him why he was quitting. In 8 months, the client successfully quit smoking and was able to reconnect with his daughter. The client has now been in the maintenance stage for several months now.

Added costs of program due to clients' linguistic needs—A major consideration of implementation according to the RE-AIM framework is the costs of the implementation in terms of money, time, and other resources. As is common in service delivery with limited English proficient clientele, translation was a major strain on the delivery of the intervention. Given that the majority of ACMHS' client population possesses limited to no English proficiency, all content must be translated into a multitude of Asian languages. For the smoking cessation group program, two facilitators (one Korean and one Cantonese) took turns speaking in English, and then translating into both Korean and Cantonese in order to accommodate a few clients who did not speak English. Because of the workload burden, ACMHS clinicians were not been able to translate all available assessment, psychoeducation, homework, and other materials into different Asian languages and instead needed to verbally translate often-complex text in group session. Clinicians voiced frustration that this added burden meant they were not always able to cover every learning objective and lesson plan.

Maintenance

The dimension of maintenance refers to sustained gains on primary and secondary outcomes for clients at the individual level as well as the longer term impact of the program at the

setting level (i.e., whether the program is still ongoing, if and how it was adapted long term, how it aligned with the organization's mission, how financially sustainable it is). Individual-level measures of maintenance were not collected from intervention participants. Therefore, we are unable to provide information regarding whether participants maintained smoking reduction or cessation or whether other broader outcomes were maintained.

Regarding maintenance on the setting level, group and individual smoking cessation counseling is still being offered by the clinic. However, based on client feedback, smoking cessation programs are no longer offered as stand-alone programs but rather fully couched within a "whole health"/wellness context and integrated into existing wellness services. Materials that had been translated into Korean, Chinese, and Cambodian are used, but clinicians are still unable to offer translated materials in every language spoken by the clientele. Smoking cessation has been integrated into the clinical workflow. Tobacco use is now assessed at initial intake with new clients. If clients smoke, smoking cessation is encouraged to be one of their treatment goals. Certain components of smoking cessation counseling used, such as materials needed to track carbon monoxide readings, may not be financially sustainable for the clinic in the long term, but the clinic is committed to offering smoking cessation counseling to all interested clients.

DISCUSSION

Immigrants with SMI are among the most vulnerable Asian Americans with respect to high prevalence of tobacco use, high prevalence of tobacco-related diseases, and lack of empirically supported smoking cessation interventions. As we attempt to better understand the "black box" of translation from effectiveness research to everyday practice (Zapka et al., 2004), we have learned several lessons that have implications for clinicians, researchers, and policymakers interested in reducing tobacco use among Asian immigrants with SMI.

Several cultural issues influence the delivery of smoking cessation programs to Asian immigrants with SMI. It is well documented that in many Asian cultures, relationships are of central importance, serving to define one's identity and values and drive goal-directed behavior (Saw & Okazaki, 2012). One important cultural consideration we have learned is the power of the client–therapist relationship to engage clients in smoking cessation counseling. Many clients are socially isolated and reluctant to trust unfamiliar individuals, including other clinicians they do not know. Therefore, all clinicians should receive adequate training in smoking cessation counseling, as they may be the only professionals to whom their clients will respond. Furthermore, family factors (e.g., policies for smoke-free homes, perceived family norms) are associated with intention to quit smoking among different Asian ethnic groups (Garcia, Romero, & Maxwell, 2010; Kim, Ziedonis, & Chen, 2007; Tsoh et al., 2011), therefore, emphasizing the positive consequences of quitting on significant relationships (e.g., greater harmony) is an important and culturally appropriate message in smoking cessation programs targeting Asian Americans. Culture and gender influence smoking behaviors in complex ways that are not well captured in mainstream smoking cessation treatments. Furthermore, even within this client population, gender norms can vary widely by country or region of origin. More research is needed to better understand these complexities.

Language access is among the most difficult barriers to overcome in implementing and evaluating smoking cessation counseling for Asian immigrants with SMI. Clinics such as the one highlighted in this article are often overwhelmed by the linguistic needs of their clientele. Language issues impact most dimensions of the RE-AIM model. Reach is impacted in that only clients who are matched with language-concordant providers are able to receive services. Effectiveness is difficult to measure when outcome measures need to be translated. More important, the fidelity and dosage of interventions can be adversely compromised by language demands. Implementation is difficult to track and the intervention and modifications made are hard to apply uniformly across clinicians. In addition to smoking cessation programming being more costly because of clients' language needs, they can also be more difficult to maintain with the high clinician turnover that is common in many community clinic settings.

One future consideration to assist with language and staff burden is integrating referrals to the California Smokers' Helpline, whose free telephone counseling services and self-help educational materials are available in Cantonese, Mandarin, Vietnamese, and Korean (Zhu et al., 2012). This service is now available nationally as the Asian Smokers' Helpline, funded by the Centers for Disease Control and Prevention for 1 year, which makes it feasible for nationwide dissemination and health systems change. Such quitlines, which have demonstrated in trials to double quit rates (Sherman et al., 2008), are already serving a significant population with behavioral health issues and there is now a national Quitline Behavioral Health Advisory Forum (Morris, 2010). Since the clinician–client relationship is so important, a clinician could conduct a "warm transfer" to facilitate a hand-off to the Helpline counselor; this was done in the Veterans Administration clinical setting as part of a care coordination program (Sherman et al., 2008). Future studies might examine the utilization patterns and efficacy for Asians with SMI using this resource, which would require continued funding and support.

In addition to these lessons learned, which are specific to the needs of Asian immigrants, we also echo the experiences voiced by others developing or providing health promotion services for clients with SMI. Emphasizing wellness and overall health rather to focusing on smoking cessation is more palatable for many clients, especially those not yet motivated to stop smoking (Williams et al., 2009). In addition to lectures and written materials, clients respond to experiential activities and opportunities for skill building (Williams et al., 2009). Finally, peer support for wellness and smoking cessation goals is well received by this clientele (Ashton, Mulconray, Weston, Rigby, & Galletly, 2012; McKay & Dickerson, 2012). These reflections and recommendations for enhancing smoking cessation interventions for Asian Americans with SMI would be enhanced with consumer input and more rigorous analyses of processes and outcomes of treatment in future studies.

CONCLUSION

Providing smoking cessation counseling for high-need, traditionally underserved populations such as Asian immigrants with SMI is not so simple as picking up an empirically supported treatment and implementing it without modifications. Though funders are placing demands and providing resources to train clinicians on smoking cessation

interventions, still there are often inadequate resources to implement these interventions. Additional resources (e.g., multilingual and multicultural staff, staff time, language translation services, and money) are required to meet the linguistic, cultural, and psychological needs of this population and to allow for more rigorous study of how evidence-based smoking cessation interventions are implemented within these complex settings. A future consideration is integrating the Asian Smokers Quitline into the clinical workflow, especially as quitlines are being heralded as a systems change for behavioral health to address tobacco use.

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TABLE 1

Demographic Information for Asian Community Mental Health Services' Consumers With Serious Mental Illness in 2005.

	n	%		n	%
Ethnicity			Gender		
Cambodian	90	19.0	Female	259	54.0
Chinese	203	42.0	Male	224	46.0
Filipino	26	5.0	Total	483	100.0
Japanese	14	3.0	Education		
Korean	24	5.0	None	79	18.0
Lao/Mien	43	9.0	6th grade or less	74	16.0
Vietnamese	73	15.0	7th–11th grade	114	25.0
Other Asian	8	2.0	High school graduate	96	21.0
Non-Asian	2	0.4	Some college	57	13.0
Total	483	100.0	College degree or higher	29	6.0
Primary language			Unknown	34	
Cambodian	80	17.0	Total known	449	100.0
Cantonese	156	32.0	Insurance		
Japanese	7	1.0	Medicaid/Medicare	79	16.0
Korean	15	3.0	Medicare	4	1.0
Mandarin	18	4.0	Medicaid	294	61.0
Mien	36	7.0	Uninsured	106	22.0
Tagalog	13	3.0	Total	483	100.0
Vietnamese	67	14.0			
Other Asian	8	2.0			
English	83	17.0			
Total	483	100.0			
Income per month ($)					
0–500	262	56.0			
501–1000	165	35.0			
1001–1500	36	8.0			
1501–2000	4	1.0			

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	n	%	n	%
>2000	5	1.0		
Unknown	11			
Total known	472	100.0		

TABLE 2

Original Intervention Components and Protocol Modifications Made at Implementation.

Original Intervention Components	Modification Made at Implementation	Rationale for Modification
Combined pharmocotherapy and cognitive-behavioral counseling	Combined pharmocotherapy and cognitive–behavioral/motivational interviewing with focus on wellness and maintaining a healthy lifestyle	Most clients were not ready to quit smoking and/or felt nagged when the sole focus was smoking cessation
Lectures and written materials (e.g., handouts) in English	Translated into Korean, Chinese, Cambodian	Clients were mainly limited English proficient
Lecture and discussion format	Maintained lecture and discussion for first hour, second hour mainly physical activity such as field trips, stretching, and art projects	Clients had difficulty sustaining attention even in an interactive discussion format and responded better when learning was experiential and tactile
Discussion of alternative coping skills contains very little discussion of spirituality	Incorporation of meditation and prayer as alternative coping skills in lieu of smoking	Many clients valued spirituality
Discussion of smoking norms not gender or culture specific	Increased focus on gender and cultural smoking norms and how gender and culture interact to influence smoking behaviors	Gendered smoking norms among Asian clients differed from those in American society. These complexities are not addressed in mainstream intervention materials
A few sessions discussing coping with cravings	Every session included an active demonstration of alternative pleasurable activities and/or how to cope with cravings (e.g., facilitators took clients on a walk around the neighborhood and explored smoke-free spaces; clients and facilitators met at a local restaurant for a family-style lunch)	Clients tended to have few alternative pleasurable activities to replace smoking as a coping mechanism. Furthermore, they learned best with experiential activities
Some discussion of the impact of smoking on family members	Emphasis on enhancing family relationships as motivator to quit	Especially for older clients, their relationships with younger generations (e.g., children, grandchildren) were hurt by their smoking
Use of carbon monoxide readings to track progress	Carbon monoxide readings shared in group setting	Clients enjoyed encouraging each other by hearing one another’s carbon monoxide readings